

OCCUPATIONAL HEALTH SERVICES NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Occupational Health Services is required, by law, to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

Providing health information on the medical history form, interval history form, any other requested form or in person is voluntary. Information is used for purposes such as determining potential health hazards, differential diagnosis, and suitability for duty. Failure to provide certain health information may prohibit clinical staff from providing services relevant to that information such as denial of medication prescriptions and clearances for particular protective equipment, travel assignments, or fitness for duty. Providing incorrect information may be grounds for termination.

In accordance with the Privacy Act of 1974, as amended (5 U.S.C. 552a), you are hereby notified that: Occupational Health Services is required by the Labor and Employment Article, Title 9, Annotated Code of Maryland, The Maryland Worker's Compensation Act, and the Federal Employee's Compensation Act, as amended and extended (5 U.S.C. 8101, et seq.) (FECA), to receive and maintain personal information. Information submitted for Worker's Compensation claims is used to determine eligibility for and amount of benefits payable. Information may be provided back to the employer in order to verify statements or other relevant material. Information may be provided to providers of rehabilitation or return to work services. Information may be further disclosed as identified below. Disclosure of the social security number (SSN) to Occupational Health Services is mandatory. The SSN may be used for identification and for other purposes required or authorized by law. Failure to disclose the SSN may delay claim processing or payment of benefits. The last four numbers of the SSN are also requested when certain blood samples are placed in long term storage or tested under a unique identifier. Providing the last four numbers for this purpose is voluntary.

Disclosure of Your Health Care Information

Treatment

We may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment or healthcare operations.

On occasion, it may be necessary to seek consultation regarding your condition from other health care providers associated with Occupational Health Services.

It is our policy to provide a substitute health care provider, authorized by Occupational Health Services to provide assessment and/or treatment to our patients, without advanced notice, in the event of your primary health care provider's absence due to vacation, sickness, or other emergency situation.

Workers' Compensation

We may disclose your health information as necessary to comply with State Workers' Compensation Laws.

Emergencies

We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care about your medical condition or in the event of an emergency or of your death.

Public Health

As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.

Judicial and Administrative Proceedings.

We may disclose your health information in the course of any administrative or judicial proceeding.

Law Enforcement.

We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.

Deceased Persons.

We may disclose your health information to coroners or medical examiners.

Organ Donation.

We may disclose your health information to organizations involved in procuring, banking, or transplanting organs and tissues.

Research.

We may disclose your health information to researchers conducting research that has been approved by an Institutional Review Board.

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Routine Information Practices

We may allow you to receive copies of laboratory results, surveillance or screening results, and routine test results such as blood pressures by signing a stamped duplicate copy in your medical chart. This stamped copy serves as your release and can only be obtained by you personally, unless other arrangements have been made.

We may inform you of an impending appointment by interdepartmental mail, e-mail, or a telephone message to your work telephone number of record. If you do not wish messages to be left at this address or number, please fill out our Request for Alternate Communication form. All telephone communications will request only that you contact Occupational Health Services.

Public Safety.

It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.

Specialized Government Agencies.

We may disclose your health information for military, national security, prisoner and government benefits purposes.

Change of Ownership.

In the event that Occupational Health Services is sold or merged with another organization, your health information/record will become the property of the new owner.

Your Health Information Rights

You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that Occupational Health Services is not required to agree to the restriction that you requested.

You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.

You have the right to inspect and copy your health information.

You have a right to request that Occupational Health Services amend your protected health information. Please be advised, however, that Occupational Health Services is not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial.

You have a right to receive an accounting of disclosures of your protected health information made by Occupational Health Services.

You have a right to a paper copy of this Notice of Privacy.

Changes to this Notice of Privacy Practices

Occupational Health Services reserves the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, Occupational Health Services is required by law to comply with this Notice.

Occupational Health Services is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about your privacy rights, please contact: Carol Tobias by calling this office at 301-846-1096. If Carol Tobias is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days. I have read the Privacy Notice and understand my rights contained in the notice.

By way of my signature on the acknowledgement or like document, I provide Occupational Health Services with my authorization and consent to use and disclose my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice

Complaints

Complaints about your Privacy rights, or how Occupational Health Services has handled your health information should be directed to Carol Tobias by calling this office at 301-846-1096. If Carol Tobias is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Avenue, S.W.
Room 509F HHH Building
Washington, DC 20201

This notice is effective as of April 2003

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE

OCCUPATIONAL HEALTH SERVICES

As required by the Privacy Regulations, I hereby acknowledge that I have received a current copy of **Occupational Health Services'** "NOTICE OF PRIVACY PRACTICES," revision date _____.

As required by the Privacy Regulations, **Occupational Health Services** will explain the "NOTICE OF PRIVACY PRACTICES" to my satisfaction, after I have completed reading it. I can contact the Privacy Officer noted in the "NOTICE OF PRIVACY PRACTICES" with any questions.

As required by the Privacy Regulations, I am aware that **Occupational Health Services** has included a provision that it reserves the right to change the terms of its notice and to make the new notice provisions effective for all protected health information that it maintains.

After having read the NOTICE OF PRIVACY PRACTICES, and understanding the practices and procedures Occupational Health Services has in place to protect my personal health information, I am hereby notified I have the right to request:

A "Request for Alternative Communications" of my Protected Health Information.

A "Request for Restriction" of my Protected Health Information.

I wish to object to the following in the "Notice of Privacy Practices:"

"I understand that this office is not required to honor any changes to the "Notice of Privacy Practices."

Print Minor's Name

Parent/Guardian Signature

Date

(OFFICE USE ONLY)

Signed form received by: _____ Date: _____

Good faith effort to obtain receipt: (Describe) _____
